Making the invisible visible : the position of indigenous women in Mexico. A general overview of the challenges ahead
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IV. Women and Health Care in Mexico: The Need for Education, Prevention, and an Intercultural Approach

Of all Mexicans, approximately one out of ten persons is indigenous[41] (INEGI, 2010). Currently, they are the most vulnerable population group in Mexico, with the lowest socio-economic level of development. They suffer from poverty and have limited access to public services and education. The lack of adapted medical health care, especially in rural and indigenous regions, is one of the most basic issues Mexican indigenous peoples are facing. This problem affects entire communities, however, women and children are particularly vulnerable. The levels of malnutrition, infant mortality, and maternal mortality are considerably higher in indigenous than in non-indigenous communities.

This chapter will focus on some of the health risks Mexican women are confronted with, and more particularly the health risks related to reproduction and maternity. Even for these natural processes, the available medical care in Mexico does not always seem to be adequate. All Mexican women, both indigenous and non-indigenous, can encounter the problems described here. However, the risks women face vary, depending on their economic possibilities and depending on their geographical location. Women in rural communities are disadvantaged, but indigenous women are even more vulnerable. We will look at certain factors impeding access of indigenous women to adequate health care. The main questions that will be asked here are: which basic health risks are indigenous women facing, and what needs to be improved in Mexican health care to offer an adequate service to indigenous communities, and thus reduce their health risks?

Article 24 of the UNDRIP indicates that an approach to health care for indigenous peoples should be twofold. On the one hand indigenous peoples should have the right to maintain their traditional medicine and health practices, on the other hand they should have equal access to all social and health care services, without being the subject of discrimination:

> "Article 24
>
> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

[41] Based on self-ascription.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right (UN, 2007)."

The Mexican Constitution obliges authorities to guarantee access of indigenous peoples to the national health care system. It also states that traditional medicine should be used when advantageous.

"Article 2. The Mexican Nation is one and indivisible.

[…]

B. To promote equal opportunities for indigenous peoples and eliminate any discriminatory practice, the Federation, States, and Municipalities, will establish the institutions and determine the necessary policies to ensure the observance of the rights of indigenous peoples and the integral development of their peoples and communities, which should be designed and operated together with them.

To eliminate the shortcomings and lags that affect indigenous peoples and communities, these authorities have the obligation to:

[…]

III. Ensure effective access to health services by expanding the coverage of the national system, also making proper use of traditional medicine, and support nutrition among indigenous peoples through food programs, especially for children (Cámara de Diputados, 2014a)[42]."

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[42] Original:
"Artículo 2o. La Nación Mexicana es única e indivisible.
[...]
B. La Federación, los Estados y los Municipios, para promover la igualdad de oportunidades de los indígenas y eliminar cualquier práctica discriminatoria, establecerán las instituciones y determinarán las políticas necesarias para garantizar la vigencia de los derechos de los indígenas y el desarrollo integral de sus pueblos y comunidades, las cuales deberán ser diseñadas y operadas conjuntamente con ellos.
Para abatir las carencias y rezagos que afectan a los pueblos y comunidades indígenas, dichas autoridades, tienen la obligación de:
[...]
III. Asegurar el acceso efectivo a los servicios de salud mediante la ampliación de la cobertura del sistema nacional, aprovechando debidamente la medicina tradicional, así como apoyar la nutrición de los indígenas mediante programas de alimentación, en especial para la población infantil (Cámara de Diputados, 2014a)."

Many government programs have been developed to improve health care in indigenous communities, however, progress is slow. According to Soledad González Montes, this is partly due to a lack of information on the condition of indigenous peoples. Some specific studies have been made, but there is a pressing need for up-to-date and accurate data. The data collected by health surveys give a certain idea of the problems faced by health care services. However, little is known about the real needs of the potential users of these services (González Montes, 2003: 3, 8).

The impact of culture on health care is one of the elements that has not received due attention, and is often even ignored by medical practitioners in Mexico. Cultural traditions, religious beliefs, including taboos, can influence the patients' experience of illness and health care. To address the health situation of indigenous peoples, it is essential to understand their perspective on health, illness, and medicine.

Here could lie a role for anthropologists, advocates, and indigenous experts. They have the ability to approach indigenous communities from a cultural perspective. They are in a privileged position, between the indigenous community and the occidental way of thinking. Their understanding of indigenous cultures makes it possible for them to be a link between the two cultures. Anthropologists could bring them together, and improve their mutual understanding. Thus, the anthropologist would transcend the theoretical level of his field of study, and commit on a social level. It would be best if anthropologists and advocates team up with indigenous experts and – in general – if indigenous experts, indigenous researchers, and indigenous students (female and male) take over the discipline of anthropology in a reconstruction of their own cultural history and an analysis of the socio-economic and political issues in their communities.

In their research, anthropologists do not always consider concepts of body and illness. This is often seen as something specific for medical anthropology. When discussed, it is looked at from a descriptive perspective. The anthropologist can, for example, explain the dual concept of 'hot' and 'cold' in Mesoamerican cultures[43] (e.g. Monaghan, 1995; Olavarría, 2009). But the question is rarely

[43] According to this concept, everything that surrounds us has a 'hot', 'neutral', or 'cold' characteristic. A person needs to preserve the balance between the elements. A disruption of this balance can lead to disease. Therefore, in specific circumstances certain types of food should, for example, be avoided. For more discussions on the hot and cold dichotomy and on its origins see among others: J. M. CHEVALIER and A. SÁNCHEZ BAIN (2003), *The Hot and the Cold: Ills of Humans and Maize in Native Mexico*, Toronto: University of Toronto Press; G. M. FOSTER (1953), "Relationships between Spanish and Spanish-American Folk Medicine", in: *Journal of American Folklore*, 66, p. 201-217; A. LÓPEZ AUSTIN (1980), *Cuerpo humano e ideología: las concepciones de los antiguos nahuas*, Mexico: UNAM; B. R. ORTIZ DE MONTELLANO (1980), "Las yerbas de Tláloc", in: *Estudios de Cultura Náhuatl*, 14, p. 287-314; B. R. ORTIZ DE MONTELLANO (1986), "Aztec Sources of Some Mexican Folk Medicine", in: STEINER, R.P. (ed.) *Folk Medicine. The Art and the Science*, Washington, D.C.: American Chemical Society, p. 1-22; B. R. ORTIZ DE MONTELLANO (1989), *Syncretism in Mexican and Mexican-American Folk Medicine*,

asked what the relation is between traditional concepts and allopath medicine. How do Western and Mesoamerican concepts of health interact in the lives of indigenous peoples? What influence do the traditional beliefs have when visiting an allopath doctor? Anthropologists tend to focus on the traditional medicine, and rarely discuss situations in which indigenous peoples go to allopath doctors. Very little discussions can be found about the problems indigenous peoples experience within the Mexican occidental health care system, or about the lack of access to medical services.

A brief overview will first be given of the general situation of health care in Mexico. Then we will turn to specific health issues women are faced with. First, the focus will lie on reproductive health, including family planning, the use of contraceptives, the medical and emancipatory consequences of teenage pregnancies and early marriages, abortion, and forced sterilizations. For each topic the current situation of Mexican women will be analyzed, with specific attention for indigenous women. Subsequently, we will look more closely at maternal health. In this context, the high levels of maternal mortality within indigenous communities are an indicator for a larger problem. Therefore, the importance of an intercultural approach to health care will be discussed. Attention will be given to the difficulties indigenous peoples are confronted with within occidental medicine, and to the role traditional medicine could be playing to improve the medical care offered to indigenous communities. To illustrate this, the role of traditional midwives or *parteras* will be explained, as well as the need for a humanization of delivery in Mexico.

The available data on health care in Mexico, and especially health care studies with a gendered or cultural perspective, are very limited. The information for this chapter was obtained by analyzing specialized literature. Soledad González Montes, Roberto Campos Navarro, and Sheila Cosminksy are among the few scholars that have more recently been working on health care in Mexican indigenous communities. This information was complemented with survey results and statistics from official institutions, such as the Instituto Nacional de Estadística y Geografía, the Instituto Nacional de Salud Pública, and the Consejo Nacional de Población. However, the available statistics are again very limited.

In addition, two interviews were conducted with experts working in the medical field. The first interview was with an indigenous woman. Flor Julián Santiago is Mixtec, from San Antonio Huitepec in the state of Oaxaca. She studied medicine, and has an additional masters' degree in medical sciences. Flor Julián has worked with indigenous communities with Doctors Without Borders, mostly in Oaxaca and Chiapas. She also has family members who are traditional healers. Although she has

College Park: University of Maryland; I. SIGNORINI (1989), "Sobre algunos aspectos sincréticos de la medicina popular Mexicana", in: *L'Uomo*, 2:1, p. 125-144.

been trained as an allopath physician, both during her studies and when dealing with patients, she has given specific attention to the cultural component in health care. The expertise and points of view of Flor Julián are important for this research, because she has experienced firsthand which problems indigenous communities are still facing regarding health care. Furthermore, she understands, both from a personal and professional perspective, the relation between allopath and traditional medicine. To gain more insight in the specific topic of maternal health, a second interview was conducted with Araceli Gil. Araceli Gil is a midwife, and director of the civil organization Nueve Lunas, based in Oaxaca. Nueve Lunas offers professional midwife trainings with an intercultural approach. For many years, Araceli Gil has also been advocating the humanization of delivery in Mexico[44]. Her experience with indigenous and professional midwifery is very valuable for a better understanding of the specific situation of indigenous women. It fosters reflection on a health care system that would work in an intercultural context.

A. General Health Care Situation in Mexico

The health situation in Mexico has improved during the last decades. Life expectancy increased significantly, from 48 years in 1950 to 74.5 years in 2013, and child mortality was also reduced by almost two thirds between 1990 and 2011. Vaccination blocked infectious diseases, and there are fewer problems related to malnutrition. Better life conditions in general, as well as an improvement of the national health care system contributed to this progress (FUNSALUD, 2006; CONAPO, 2013).

Although significant efforts have been made, there are still serious shortcomings at different levels, such as the lack of resources for health care services. In the year 2000, Mexico only dedicated 5.1% of its GDP to health (OECD, 2011). In comparison, other Latin-American countries with similar levels of development, such as Argentina and Uruguay, spent more than 8% of their GDP on health care[45] (FUNSALUD, 2006: 22). By 2012, 6.2% of Mexico's GDP was spent on health care[46]. Although this meant an increase since the year 2000, it is not enough to offer satisfactory health care services to the entire Mexican population. Moreover, only 50.6% of health costs were financed by public funds in 2012 (OECD, 2014).

[44] For more information on the civil organization Nueve Lunas: www.nuevelunas.org.mx
[45] For further comparison: In the year 2000, Belgium spent 8.1% of its GDP on health care, the Netherlands 8%. In 2009, Belgium spent 10.9% and the Netherlands 12% (OECD, 2011).
[46] Remark: The exact percentages mentioned by the OECD and the WHO may vary, but the overall trend remains the same.

Furthermore, resources are not equally distributed across the country. The richer northern states (e.g. Coahuila, Baja California Sur, Nuevo León) have more and better health care services compared to the less affluent southern states (e.g. Chiapas, Oaxaca, Guerrero). Specialized and high level modern hospitals are concentrated in more wealthy urban areas, and just over 50% of the infrastructure is located in Mexico City. The poorer regions, in particular rural areas and low-income urban places, with a high amount of uninsured people, have less doctors and hospital beds available (OECD, 2005: 78-79). Especially indigenous peoples have limited access to both medical staff and medical infrastructure. Indigenous communities are still exposed to diseases such as diarrhea or respiratory infections, which could be treated and prevented very easily and at low cost (FUNSALUD, 2006: 26; Julián, personal communication, 2012). In many indigenous communities maternal health is also at risk due to a lack of prenatal attention and support during the delivery. This issue will be discussed in detail further on.

As the number of health care centers in rural areas is limited, people often have to travel a considerable distance to get medical attention. For example in July 2011, on the bus traveling from the city of Puebla to the indigenous town of Cuetzalan del Progreso (Sierra Norte, state of Puebla), I met a woman of about 65 years old. She was bilingual (Nahuatl-Spanish) and lived in a neighboring village of Cuetzalan. She did not often go to Puebla, but now she had been there for some medical exams. In January 2011, a new hospital had been inaugurated in Cuetzalan, but by July the hospital was still not fully functional, only attending emergencies and offering external consults. There were also failures in the supply of electricity, potable water, and material in general. The nearest hospital for her specialized exams was in the city of Puebla. So she had to travel eight hours by bus to go back and forth to Puebla, with a total bus fare of 308 Mexican pesos[47]. For many people public transport is too expensive, and thus they have no means to get to the nearest health care center. If one considers that the level of marginality is often linked to the health situation, it is contradictory that so few resources are made available for the people who would benefit most from better health care (Name unknown, personal communication, 2011; Municipios Puebla, 2011; OECD, 2005: 78-79).

Mexico has both a public and a private medical care system. The public health care sector is organized by the Secretaría de Salud (Health Secretary). The private sector is generally considered to be of better quality, but lacks any form of control. Health care costs can vary, but usually private medical practices and private hospitals are much more expensive, primarily because social security does not intervene. For public sector medical care, patients can affiliate with one of the national health insurance institutions, such as the Instituto Mexicano del Seguro Social (IMSS), the Instituto de

[47] In 2011, the daily minimum wage in the state of Puebla was 56.70 Mexican pesos (CONASAMI, 2011).

Seguridad y Servicios Sociales de los Trabajadores del Estado (ISSSTE), the Servicios Estatales de Salud (SESA), or the Seguro Popular de Salud[48]. Each institution has its own network of hospitals and health care centers across the country. The IMSS is meant for salaried workers of the formal economy, the ISSSTE for government employees. The Seguro Popular de Salud was created in 2003 by the Secretaría de Salud as part of the new System of Social Protection in Health (*Sistema de Protección Social en Salud*). The goal was to make health insurance available for Mexicans that did not have any insurance yet, especially those in rural areas where other insurance institutions are less represented (FUNSALUD, 2006: 23). However, more than 50% of Mexicans still lacked health insurance by 2011 (SINAIS, 2011). Furthermore, the health insurance institutions most available for the poorer population groups, the Secretaría de Salud and IMSS-Oportunidades[49], receive the lowest resources from the government (González Montes, 2003: 7).

Although the Mexican government has been increasing the number of health care centers and ambulatory health services, there is also the issue of the quality of the services offered. The quality of Mexican health care varies considerably. Some places offer high level health services that can compete with the best in the world, but there are also many centers unable to meet a minimum standard in health care. In some cases trained doctors and nurses are available, but they lack the necessary material and infrastructure. It can on the other hand also be a problem of inexperienced or unqualified medical staff. Several medical schools are not certified, and thus not all medical practitioners have the desired level of preparation. Not even all hospitals are certified, either in the private or public sector (OECD, 2005: 89, 103-106; FUNSALUD, 2006: 25).

The Mexican government is trying to change this situation, amidst a growing consideration for the rights of patients and for the improvement of medical attention (OECD, 2005: 98). But a lot remains to be done, especially in low-income areas. Besides, establishing an appropriate health care policy is further hampered by a lack of reliable data and health statistics. To give an example, maternal and infant mortality is not systematically recorded, making it impossible to get a clear idea about the extent of the problem (FUNSALUD, 2006: 28).

Access to medical care, both physically and financially, and quality of health services remain major challenges. The problems regarding Mexican health care are most critical in rural areas, including indigenous communities. The lack of medical attention affects everybody in these communities, however, women and young children are especially vulnerable.

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[48] Employees of the Mexican army and of the national petroleum company PEMEX can get insured at the Instituto de Seguridad Social para las Fuerzas Armadas Mexicanas (ISSFAM) and at the Servicios Médicos de Petróleos Mexicanos respectively.
[49] Until 2002 called IMSS-Solidaridad.

B. Reproductive Health: The Right to Decide and the Importance of Education in Preventing Health Risks for Women

In addition to general health issues such as infections, diseases, or fractures, at a certain time in their life most women are confronted with specific conditions related to sexual reproduction and child bearing. Although pregnancy and delivery are natural processes, they engender some health risks that can turn bad if the mother does not receive appropriate care. Since the 1994 United Nations *International Conference on Population and Development* (ICPD) in Cairo, reproductive health has increasingly been recognized as an important issue worldwide (UNFPA, 2011).

There have been two different perspectives to address the subject of reproductive health. The first one was developed during the 1994 ICPD in Cairo. Based on feminist theory, it considers reproductive and sexual rights to be human rights. Obtaining these rights is part of the empowerment of women in the process towards gender equality. The second only looks at reproductive health from the perspective of family planning and sexual health. This limiting viewpoint mainly aims at reducing fertility rates among poor segments of the population in an attempt to tackle poverty. Since the 1994 ICPD, Mexican government has introduced the concept of reproductive health in health care programs. However, Mexican health care services often still fall back on the restrictive perspective. Therefore, there is an urgent need for a more general approach to reproductive health in Mexico (González Montes, 2003: 5-7).

Moreover, an important discrepancy can be noted between the institutional discourse on reproductive and sexual health, and the real practices in Mexico. Awareness of the importance of a broad approach to reproductive health and the adoption of a gender perspective, seem to vary depending on the hierarchical level of the health care services. At an institutional level, these concepts are accepted and regarded as important. The lower levels, and thus the people working in the field, however, are less acquainted with these concepts and with the consequences this has on their work (González Montes, 2003: 7-9). As rural and indigenous communities are most vulnerable, medical practitioners working in these areas should be particularly vigilant and well prepared to address issues regarding reproductive health.

In what follows, central topics related to the reproductive health of women, such as family planning and contraception, teenage pregnancies, abortion, and forced sterilization will be discussed, to illustrate some of the main health risks Mexican women are exposed to. These risks can be faced by women in different socio-economic contexts, however, the problems are significantly more acute for women in marginalized positions, and in particular for women in indigenous regions.

1. Family Planning and Contraception

As a result of the General Population Law of 1974 (*Ley General de Población*), and of the modification of Article 4 of the Mexican Constitution, the Mexican government has been organizing campaigns in favor of family planning since the 1970s (INEGI, 2009b: 34). Family planning gives individuals and couples the opportunity to decide how many children to have, and when to have them. This can be done through the use of contraceptive methods, or conversely by the treatment of infertility (WHO, 2011a). The World Health Organization (WHO) stresses the importance of family planning in the lives of women: "A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy (WHO, 2011a)." Consciously spacing and planning pregnancies can reduce health risks in general. Young women can limit early childbearing, and the related health risks for themselves and their babies. Consequently maternal and infant mortality can be reduced. Preventing adolescent pregnancies can also have a positive impact on the future perspectives of young women, as they would be able to continue their education. The reduction of unwanted pregnancies also lowers the rates of unsafe abortions. Moreover, family planning empowers people by enabling them to make their own conscious choices, and to gain control over their social and economic development (WHO, 2011a).

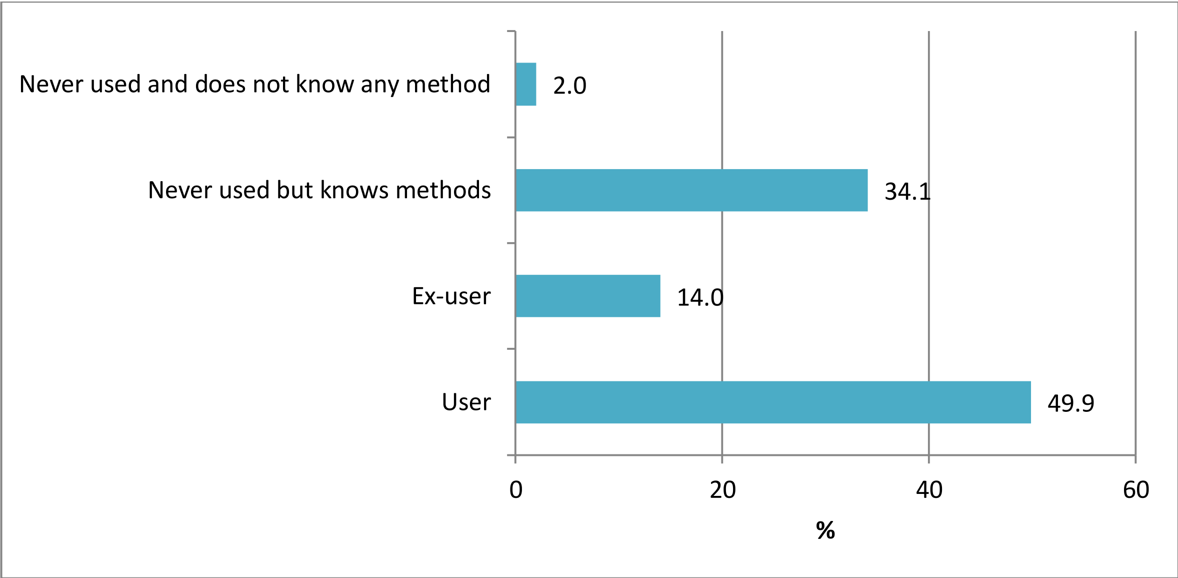
Family planning campaigns have shown results in Mexico. In 1974, Mexican women had an average of 6.11 children. In 1999, the fecundity rate was down to 2.48 children per woman, and in 2013, women had an average of 2.2 children (CONAPO, 1999: 29; CONAPO, 2013). Although the national average is low, there are differences in the number of children, depending on socio-economic factors. Generally speaking, Mexican women living in urban regions have less children than those living in rural areas. The educational level of the mother also has an influence. Mexican women without completed primary education have approximately four times more children than women with higher education. On average, indigenous women have more children than non-indigenous women. Not surprisingly, Chiapas and Guerrero, two states with the lowest socio-economic level and with high percentages of indigenous population, rank among the highest fecundity rates of the country (INEGI, 2009b: 39-40). It is important to consider these variables in light of family planning policies. Campaigns should first target the most vulnerable groups: in Mexico these are indigenous women, with low education, living in rural areas.

As mentioned before, since the 1970s, the Mexican government has been organizing campaigns in favor of family planning and to promote the use of contraceptives. However, the actual use of contraceptives is still not that common (INEGI, 2009b: 34).

In the 2009 national demographic survey (*Encuesta Nacional de la Dinámica Demográfica*), a distinction was made between women who have a certain knowledge of contraceptive methods and those who actually use them. The results showed that 98% of women at reproductive age (15-49 years) knew or “ever heard the mention of” at least one contraceptive method. This would mean almost all Mexican women know how to prevent pregnancies. In practice, however, it is not because a woman ever heard about such a method that she has a good knowledge about the correct use. It is also imperative to notice that in 2009, in the states of Chiapas and Oaxaca respectively, 12.6% and 6.7% of women between 15 and 49 years had never heard about any contraceptive method (INEGI, 2009b: 34).

When looking at the actual use of contraceptives, in 2009 only 49.9% of Mexican women between 15 and 49 years reported using contraceptives. Just over 34% claimed to know contraceptive methods but never to use any, and 2% of women did not know any contraceptive method (see figure 1) (INEGI, 2009b: 34).

Figure 1: Percentage of women between 15 and 49 years by use and knowledge of contraceptive methods, Mexico, 2009 (INEGI, 2009b: 34).



Remark: Although the women using them might consider them as such, remedies that have not proven to prevent pregnancies, such as teas, were not included as contraceptive methods in these results (INEGI, 2009b: 34).

For people living in a stable union, contraceptives are mostly used to limit the number of children or plan pregnancies. In 2009, an average of 72.5% of Mexican women living in a couple reported using contraceptive methods. In the states with the best scores, almost 80% of women in a union used contraceptives (Sonora: 79.9%; Sinaloa: 79.8%; Federal District: 79.6%; Nuevo León: 79.2%). However, the lowest state averages were less positive, and could primarily be found in states with a lower socio-economic profile (Chiapas: 54.9%; Guerrero: 61.4%; Michoacán: 63.2%; Oaxaca: 63.4%) (see figure 2) (INEGI, 2009b: 35).

When looking at the different generations, an increase in the use of contraceptives is noticeable. The older generations report less use of contraceptives the first time they had intercourse (see figure 3). In 2009, 38.2% of girls between fifteen and nineteen years of age reported having used contraception during their first sexual relation; in the age group between 45 and 49 years only 9.2% of the women did (INEGI, 2009b: 37). In recent years, more improvements can be seen. In 2012, 66.6% girls between twelve and nineteen years had used contraceptive methods during their first sexual relation. Of the boys in that same age group, 85.3% reported having used contraception during their first sexual relations (INSP, 2012: 74-75).

Figure 2: Percentage of women between 15 and 49 years, living in a union, and using contraceptive methods, per federal entity, Mexico, 2009 (INEGI, 2009b: 35).

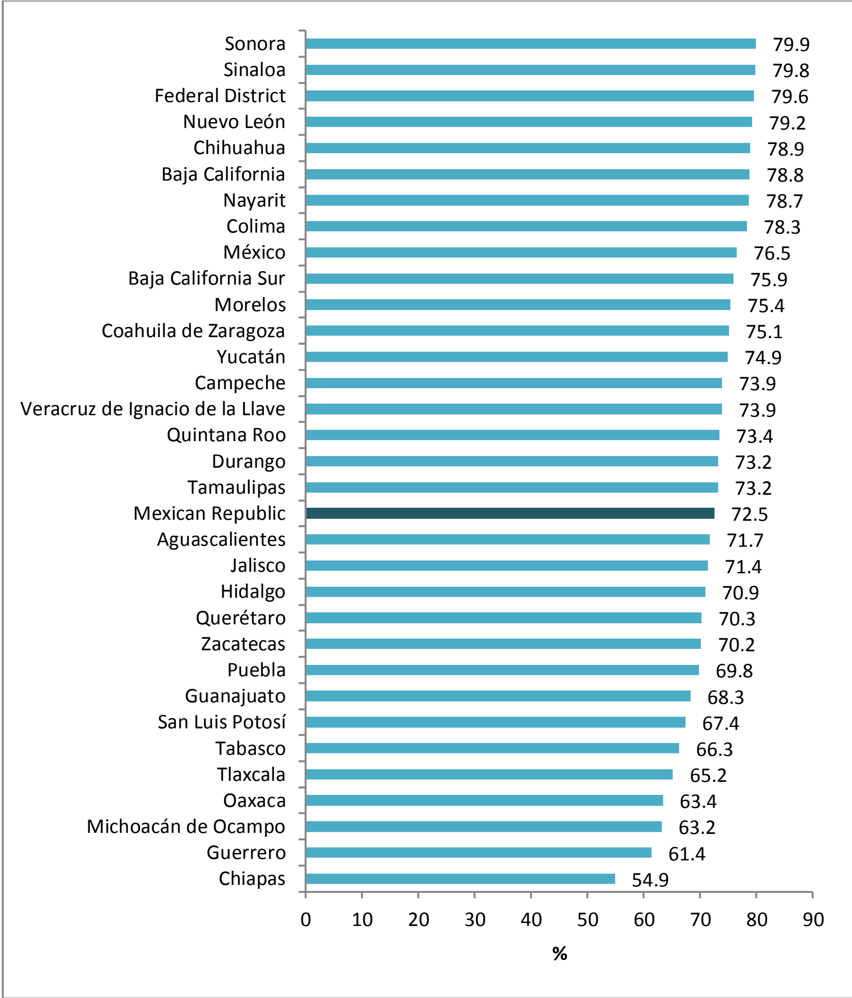
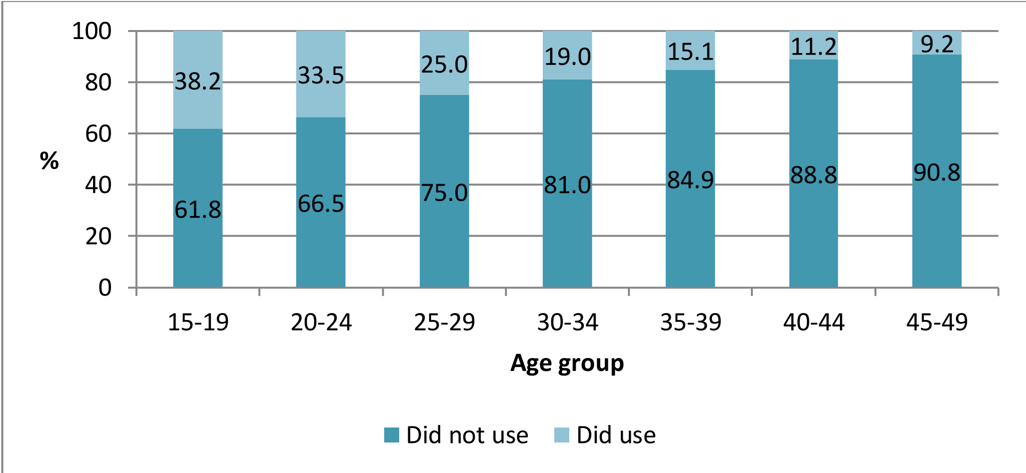


Figure 3: Percentage of women between 15 and 49 years according to their use of contraceptives during their first sexual relation, per age group, Mexico, 2009 (INEGI, 2009b: 37).



Among all contraceptive methods, the condom is most accessible for everybody, and most often used. Unlike pills or injections, no prescription nor medical intervention is required. When used correctly and consistently, condoms have an effectiveness of 98% to prevent pregnancy. Additionally, it protects against sexually transmitted diseases, and can reduce the risk of an HIV infection by 80% (INEGI, 2009c: 100; WHO, 2011a).

In the year 2000 national health survey (*Encuesta Nacional de Salud 2000*), the Centro Nacional para la Prevención y el Control del VIH/SIDA (CENSIDA) investigated the use of condoms among Mexican youths between the age of 15 en 24 years. The age group from 15 to 19 years of age was asked what they or their partner had done or used to prevent pregnancy or disease the first time or whenever they had sexual relations[50]. The group between the age of 20 and 24 was asked what they or their partner were currently doing to prevent pregnancy[51]. In the survey, 47.8% of men between 15 and 19 years indicated to use condoms. On the other hand, only 15.1% of the women of the same age group said to use a condom. In the age group between 20 and 24 merely 9.8% of male and 6.4% of female participants indicated to use a condom during sexual relations (INEGI, 2009c: 100; Secretaría de Salud, 2000).

In the 2012 survey on health and nutrition (*Enquesta Nacional de Salud y Nutrición – ENSANUT 2012*), 90% of the adolescents between 12 and 19 years indicated to know contraceptive methods. In this survey, 80.6% of the boys and 61.7% of the girls between twelve and nineteen years reported to have used a condom the first time they had sexual intercourse (INSP, 2012: 73, 75).

In general, all these figures are low, bearing in mind that the statistical number of people claiming to have used contraception is probably higher than the actual amount of people really having used it. Considering that this topic is intimate and often taboo, respondents may have been inclined to answer what they think is socially accepted.

2. Teenage Pregnancies and Early Marriage: Limiting Emancipation

During the last decades, sexual education has gradually entered the curriculum of Mexican primary education. However, it seems that not all young people are equally well informed about sexual relations and the possible consequences. Mexico has an important number of teenage pregnancies. As many as 13% of women that gave birth in 2013 were 18 years or younger. In absolute numbers, Mexico, Chiapas, and Veracruz were the states with most teenage pregnancies. These are also the states with the highest number of births in general. The number of teenage pregnancies starts to

[50] Original question: "La primera vez o esa vez que tuviste relaciones sexuales, ¿qué hicieron o usaron tú y tu pareja para evitar un embarazo o una enfermedad?" (Secretaría de Salud, 2000: question 5.4).
[51] Original question: "¿Qué están haciendo tú o tu pareja para no tener hijos? (Secretaría de Salud, 2000: question 5.22).

increase from the age of 14 years, but there are also reports of girls as young as 10 years of age giving birth. In 2013, over 8% of Mexican teenage mothers were between 10 and 14 years old. Again the states of Mexico and Chiapas were home to most of these girls (INEGI, 2013e).

Teenage pregnancies can be the undesired consequence of unprotected sexual relations. But in Mexico, teenage pregnancies can also be the result of very early marriage. In 2012, the average marriage age for Mexican women was 26.6 years. Men were on average 29.4 years at the time of their first marriage. In Guerrero, the state with the lowest average, women got married at about 23.5 years. In the Federal District they were on average 29.8 years old (INEGI, 2012a). However, women in rural areas and indigenous communities tend to get married earlier than girls in urban areas. The Mexican Civil Code defines that the minimum legal age for men to get married is sixteen years; women are allowed to marry as young as fourteen years old (Cámara de Diputados, 2013a: Art. 148). But in some regions with a lower socio-economic profile, girls as young as twelve years of age are getting married. According to official statistics, as many as 13.8% of Mexican women getting married in 2012 were eighteen years or younger; 0.4% of girls are younger than fifteen years old when they got married. Most girls marrying at eighteen years or younger were from Guerrero (31.9% of women getting married in that state), Chiapas (23.6% of women getting married), and Oaxaca (20.9% of women getting married). But all states, except Aguascalientes, Quintana Roo, and Campeche, recorded marriages of girls under fifteen years of age. In absolute numbers, the states of Guerrero, Veracruz, Oaxaca, and Mexico had most marriages of girls under fifteen years, with Guerrero and Oaxaca standing out, showing 2.8% and 1.2% of marriages with girls under fifteen years of age respectively. In 2012, there were 246 Mexican girls getting married under the age of fourteen (0.04%), basically not meeting the legal marriage age. The state of Guerrero has most of these early marriages. Fifteen out of the twenty Mexican girls marrying at twelve years old in 2012 were from Guerrero (Based on INEGI, 2012b).

Comparing these statistics to the marriage age of boys, it can be noted that although boys can also marry very young, their numbers are lower. At a national level, 0.01% of boys married under the age of fifteen. In 2012, 71 boys were under fifteen, compared to 2,111 girls. Of the boys, 0.06% was under sixteen and had thus not reached the legal age to get married. Guerrero, Chiapas, Oaxaca, and Mexico are the states where boys got married under the legal marriage age (INEGI, 2012c).

It has to be stressed that the numbers given here come from official statistics. It is hard to determine how accurate they are. In Mexico, the religious wedding is considered more important than the civil marriage. Especially in rural areas, often couples do not register their marriage in the national register. Thus, not all marriages are reported to the national authorities. Furthermore, there is no

certainty that the declared age of the marriage partners was correct. For one, not everybody in rural regions knows his or her exact age. Moreover, an incorrect age can be reported to avoid legal issues. It is therefore not clear what percentage of underage marriages is registered in statistical data, but it is probable that many more girls and boys are getting married at very tender ages.

Early marriage tends to have a negative influence on the emancipation of women. After marriage the girls start having children quite soon. Teenage pregnancies may be common in their community, and considered as nothing out of the ordinary by their environment. Yet teenage pregnancies entail an important health risk for the young mother and her unborn child. According to the World Health Organization, in Latin America maternal death rates are four times higher among teenage mothers under 16 years than among mothers in their twenties. Teenage mothers are significantly more susceptible to miscarriages, anemia, complications during delivery, postpartum hemorrhages, postpartum depression, and obstetric fistula, among others. The risks of stillbirths is 50% higher among mothers under 20 years than among mothers between 20 and 29 years. Babies of adolescent mothers also have considerably higher chances of preterm birth, low birth weight, or asphyxia (WHO, 2015). From a health perspective, teenage pregnancies can thus have very negative consequences both for the young girls and their babies. On a personal development level, teenage mothers are most likely to drop out of school as a result of their motherhood. They do not finish high school and are therefore unlikely to pursue further education. A low education level means only minimum wage jobs will be accessible (Riquer & Tepichín, 2001). Education is crucial for the empowerment of women; it provides an opportunity to build a better economic future for themselves and for their family, and maybe leave poverty behind. Targeted campaigns would be needed to encourage girls to finish at least high school before getting married. These campaigns should not only be directed at girls and boys, but also at their parents, and at their communities in general. Furthermore, as the Mexican state accepts marriages at a very young age, it would be an important sign of commitment of the authorities to raise the legal marriage age. However, it has to be stressed that this would only improve the legal framework. As mentioned before, in Mexico the church marriage is considered more important, while civil marriage has almost no standing. Especially in rural areas, couples very often do not register their union in the national register. Consequently, amending legislation would have a limited effect. But, there is an important role to play for the Church in this matter. The Church should encourage young girls to finish high school before getting married. This would help protect women against the health risks they face, and it would support the general emancipation of women.

Forced Marriages and the Sale of Indigenous Girls

Another issue that has to be mentioned here is the persistence of forced marriages and the sale of teenage girls in certain indigenous communities. There are reports of indigenous girls between 14 and 20 years of age being sold by their family for between 5,000 and 120,000 pesos (roughly between 300 and 7,000 euro) to get married or to do domestic work (Instituto Nacional de las Mujeres, 2013), or even worse, exchanged for a goat or pig, or sold into prostitution around the age of nine (Maldonado, 2012). More recently in March 2014, the press reported the case of Roxana Hernández Santiz, a fourteen year old Tzotzil girl of Chiapas who was imprisoned in her native village of San Juan Chamula because she had run away from the 18-year-old boy she was sold to. She would be liberated on condition that she paid back 15,000 pesos to the family of the boy – the sum they had paid for her plus interests – amounting to a total of 24,000 pesos, because she had broken the agreement her parents had made with the family by running away (Rosagel, 2014). These practices are often disguised as '*usos y costumbres'* and have taken place primarily in indigenous communities of Chiapas, Oaxaca, Guerrero and Veracruz, but also in other marginalized regions. As discussed here, early marriages leading to teenage pregnancies entail health risks for young girls. But in addition, such practices show a persisting violence against indigenous girls and women. Women's rights organizations, including indigenous women's organizations, have urged the state to take action against these practices. They are a violation of Article 2 of the Mexican Constitution which states that the '*usos y costumbres'* have to respect both human rights and the dignity and integrity of women (Reyes Díaz, 2014; Rosagel, 2014). The state, however, does not dare to intervene in these supposedly internal community matters. For the federal and state authorities it is more important not to oppose the '*usos y costumbres*' and thus avoid possible conflicts with the communities, than to protect its female citizens, even though indigenous women's organizations themselves are clearly opposed to this practice. President Peña Nieto pledged to integrate a transversal gender approach in every policy domain, however, concrete measures have not been taken against this child and women trafficking (Instituto Nacional de las Mujeres, 2013).

3. Abortion: A Taboo Topic

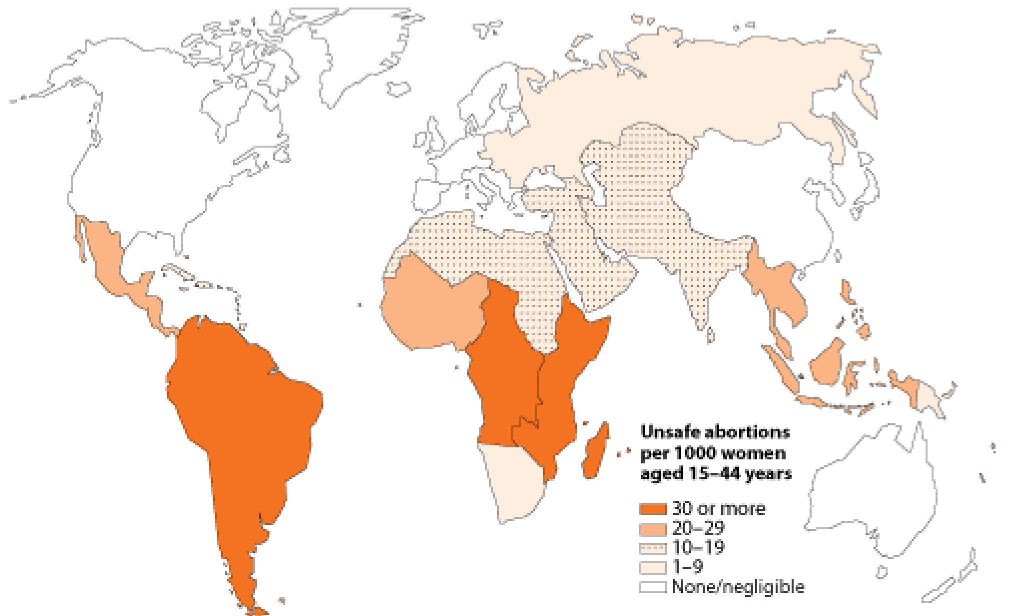
Whenever prevention and protection have failed, an undesired pregnancy can be terminated through abortion. Currently, abortion is still a taboo topic in Mexico. Yet Mexican feminists were already fighting for the right to decide over their own bodies and the legalization of abortion in the 1970s. In the 1980s and 1990s, the government recognized abortion in certain specific cases, for example after rape. Subsequently, changes of the law in favor of abortion were accepted in several states.

But, there is a lot of conservatism in Mexico. Although Mexico is a secular state, the Church has great power over society. Regarding abortion, the Mexican Church has been one of the main and fiercest opponents, as illustrated by bishops personally participating in protest marches. Even the PAN and PRI parties are strongly influenced by the Catholic Church and pursue conservative family values. As a result, there has been a retrogression in Mexican abortion laws in recent years. Currently, abortion is penalized in 17 out of 32 states. Numerous states started procedures to restrict their abortion laws even more[52]. Women have already been sentenced for having an abortion. With the anti-abortion policies, the state is in fact claiming control over the bodies of Mexican women. In 2014, only women in the Federal District were free to choose for abortion without conditions within the twelve first weeks of the pregnancy (Grupo de Información en Reproducción Elegida, 2014).

The argument of the conservative side against abortion is that they want to protect the life of any living creature, and condemn the murder of the innocent unborn child. This could be a valid argument if abortion was only about the life of the fetus. However, this argument does not take into consideration the pregnant woman. Although abortion does imply ending the life of a living organism, it can also be necessary for the health and wellbeing of the mother. Teenage pregnancies, for example, have high health risks because of the girls' young age. Therefore, girls should have the right to decide to terminate an undesired pregnancy. This would not only protect their health, but also give them the opportunity to complete their education and have more opportunities in life. Furthermore, the legalization of abortion could limit the number of clandestine abortions. The WHO estimates that in 2008 around 21.6 million unsafe abortions took place worldwide, most of them in developing countries (WHO, 2011b). The WHO map shows Mexico has a high number of unsafe abortions (see figure 4). The WHO estimates Mexico has 20 to 29 unsafe abortions for every 1000 women aged from 15 to 44 years (WHO, 2008: 20). These abortions are often performed without any medical knowledge and in dubious hygienic conditions. If abortions are not performed by trained medical staff, they can result in complications, infertility, or even in the death of the mother. Legalizing abortion makes it possible for women, who choose to terminate their pregnancy, to go to a doctor in a recognized medical facility and get appropriate care.

[52] On the reforms of the state abortion laws in Mexico see: GRUPO DE INFORMACIÓN EN REPRODUCCIÓN ELEGIDA (2013), *Iniciativas para proteger la vida desde la concepción/fecundación 2008-2013* https://www.gire.org.mx/images/stories/ley/Iniciativas_ProteccionVida_120413.pdf

Figure 4: Estimated annual number of unsafe abortions per 1000 women aged 15–44 years, by sub regions, 2008 (WHO, 2008: 20).



The belief in traditional conservative family values is still strong and widespread in all layers of Mexican society. Even on major television news programs conservative ideals are openly defended. For example, *Matutino Express* is a news program of the Televisa ForoTV channel; it brings the news, but in an informal way[53]. On July 21, 2011, the program announced a new short film about abortion, *Una mancha en el papel*[54]. This film talks about the feelings of a boy whose girlfriend aborted their baby. The boy has doubts about the abortion. The main news presenter, Esteban Arce, reacted very strongly to this movie. He thought it was excellent to show the boy's point of view and continued: "You can talk about rights, about decision-making, you can argue with laws, with some legislator, and that it is allowed during the two first weeks, but in essence it is ending a life. Life starts at the moment of conception and all you do later, you can disguise it as a decision, but it is a murder (E. Arce in Televisa, 2011a)." The presenter can of course have his own opinion on this matter. However, it is remarkable, and also upsetting, that such a public figure can proclaim his opinion as being the only right one, and impose it on his viewers. The role of a news presenter is to inform the public in an objective way, not to impose his own points of view. This example illustrates how strongly opinions on abortion are in Mexico.

[53] Televisa defines the program as follows: "Matutino Express es un concepto informativo con una visión diferente de cómo enfrentar la noticia, sin perder la seriedad pero con un toque que le arranca una sonrisa al auditorio (Televisa, 2011b)." (Translation: "Matutino Express is an information concept with a different view on how to address the news, without losing seriousness, but with a touch that makes the audience smile.")

[54] Laura Gómez Aurioles, 2011.

It has to be noted that in indigenous contexts, women have not been in favor of abortion either (Espinosa, 2009: 277). They are however especially vulnerable for teenage pregnancies, undesired pregnancies, and unsafe abortions. Alternative actions need thus to be developed, and this together with indigenous women, to find a compromise between their needs, their point of view, and the protection of their sexual health.

In my opinion, good sexual education and awareness-raising actions are essential to avoid abortions in general. And this is still an important problem in Mexico. The Secretaría de Salud started campaigns to promote the use of contraceptives by means of radio advertisements, posters at bus stops, and even billboards in large cities. However, as mentioned before, the use of contraceptives is still not widespread, and probably due to conservative influence, the anti-abortion policies are seen separate from sexual prevention.

4. Forced Sterilization of Indigenous Peoples

The government has to intensify campaigns encouraging couples to consider family planning. However, it is important that family planning remains a right and not an obligation forced upon people. In Mexico, there are reports of forced sterilizations of indigenous women and men by federal and state public health personnel.

Indigenous peoples have been threatened with the loss of government support if they did not accept to get sterilized. *Na savi* women (Mixtec) of the state of Guerrero, for example, had to accept a monthly contraceptive injection if they did not want to lose the support of the *Oportunidades* program. Others have been misinformed or deceived, and only found out later that they had been sterilized. Indigenous monolingual people, without knowledge of Spanish, and illiterate people, have been forced to sign consent forms they did not understand, to undergo sterilization. In 2002, a Chinantec woman in the state of Oaxaca was told she was getting a smear to detect cervical cancer. When she developed an infection and went to a private clinic, she learned that an intrauterine device had been placed without her consent. There have been testimonies of indigenous women receiving aid from government programs, such as *Progresa* and *Procampo*, being forced to take pills – supposedly vitamins – in front of the staff in charge of distributing aid. If they refused to take the pills, they would not get aid. Later, these vitamins turned out to be contraceptives. There have also been reports of aid staff promising 50 pesos to men who would accept a vasectomy[55], or reportedly promising to build a school or a hospital in the community to convince them. Despite several complaints, there have been no sanctions, neither against the public health staff who performed the

[55] This is approximately just under 3 euro, but in 2004, this was more than the minimum daily wage of 43.29 pesos (approximately 2.5 euro) (Comisión Nacional de los Salarios Mínimos, 2015).

sterilizations, nor against the officials who gave to order. Many of them are still working in the public health service (Magally, 2002; Proceso, 2006; Nolasco Ramírez, 2014).

These sterilizations have mainly taken place in the states of Guerrero, Oaxaca, Chiapas, and Veracruz. Forced sterilization is a severe violation of human rights. Furthermore, it is against Article 4 of the Mexican Constitution, that guarantees the right to decide freely, responsibly, and informed on the number and spacing of children (Cámara de Diputados, 2014a: Art. 4). At international level, the sterilization of population groups is even associated with genocide (UN, 1948: Art. 2).

In 2002, following reports of forced sterilization in the period between 1990 and 2001, the National Human Rights Commission (Comisión Nacional de Derechos Humanos – CNDH) wrote a recommendation to the Mexican government to address this practice (Recomendación General No. 4). The government promised to analyze the problem (Magally, 2002). When questioned by the International Labor Organization in 2004, the Mexican government denied the sterilization practices, but then in 2005, recognized the existence of forced sterilization in a report addressed to the Commission for Racial Discrimination of the UN. Yet the government has always denied this was a deliberate policy, and has claimed to be addressing the problem. What actions have been taken remains unclear (Proceso, 2006).

In 2014, Yesenia Nolasco Ramírez, federal deputy for the PRD, presented a proposition to the chamber of deputies in which she asked to make public the cases of forced sterilization of indigenous peoples known by the Health Secretary and the National Human Rights Commission (Comisión Nacional de Derechos Humanos – CNDH), to sanction the involved civil servants, to dismiss the involved SEDESOL delegates, and to dismiss all medical staff involved (Nolasco Ramírez, 2014). However, this proposal was discarded by the Commission for Indigenous Affairs and by the chamber of deputies, among others, because there was insufficient evidence that these practices were still ongoing (Cámara de Diputados, 2014b).

More research is needed to be able to determine whether the reproductive rights of indigenous women in Mexico are respected. Anthropologists, advocates, and indigenous experts could report on these situations. In addition, this illustrates the need for adequate sexual education and information for indigenous peoples, which would, for example, help them to protect themselves from abuse and deception. Finally, there is an urgent need for national and local health policies that are not in contradiction with human rights. Local health staff and officials also need to receive training and be sensitized in this regard. The national government should not hide behind local actors; it should address the severe violation of human rights and of the Constitution as a priority.

5. Women's Cancers: Another Example of the Lack of Information

A brief last comment discusses the two most lethal cancers for Mexican women.

a) Cervical Uterine Cancer

Cervical uterine cancer is an important health issue in Mexico. It is the second most deadly cancer for Mexican women (12.1%), after breast cancer (13.8%). In 2007, an average of 14.3 out of 100,000 women over 25 years died of cervical uterine cancer in Mexico. In this case too, it is a condition more present in population groups with a low socio-economic background. The highest mortality rates for this cancer can be found in Chiapas (21.8), Oaxaca and Veracruz (21.6), and Campeche (21.2) (INEGI, 2009c: 64). One of the ways to detect cervical uterine cancer is the Papanicolaou stain (also known as Pap stain or cervical cytology). However, a lack of screening and awareness makes early detection and prevention in the less developed regions difficult (INEGI, 2009c: 87). Campaigns are being launched, but this issue should definitely be included in sexual education classes at school. At this moment the SEP 6th grade natural sciences text book only includes minimal information (literally one sentence) on the papilloma virus (SEP, 2011: 41). As women and girls in rural regions are especially vulnerable, special attention should be given to them.

b) Breast Cancer

Of all cancers, breast cancer ranks first among mortality causes for Mexican women. In 2007, an average of 16.4 out of 100,000 women over 25 years did not survive breast cancer. In this case, the highest averages can be found in states with high level health care. The poor states show a low average of women dying of breast cancer (INEGI, 2009c: 65). It is not clear why the situation is so different compared to cervical uterine cancer. It could be due to a lack of screening for breast cancer. Women in these regions might die from breast cancer without knowing the real cause of their death. It is also possible that their way of life protects against breast cancer. Some factors limit the chances of having breast cancer, for example having had children, having had a first child before 30 years of age, having breast fed children, or not having used the pill too young or for long periods (WHO, 2014). Women with low socio-economic backgrounds have on average more children than women in higher social classes; they are on average younger when they have their first child; they breast feed their children for long periods; and they use less contraceptive pills. These factors could to some extent explain the lower prevalence of breast cancer in indigenous communities.

It must be pointed out that in an educational context, the screening of breast cancer is not discussed as such in the SEP 6th grade natural sciences text book. It is treated in a section called '*Un dato interesante*' ('An interesting fact') (SEP, 2011: 33). A better approach might be necessary to address the main mortality cause of Mexican women.

6. The Need for Sexual Education and Prevention

Information on family planning seems to have reached most Mexican women. However, the question remains whether this information has been complete and adequate. Neither women nor men seem to have been entirely convinced of the importance of using contraception, be it to prevent pregnancies or sexually transmitted diseases. The figures show that the problem is more prevalent in states with a low socio-economic profile; these are also the states with the highest concentrations of indigenous peoples. Limited access to contraceptives can be one of the reasons for the reduced use of contraceptive methods in rural areas. Cultural factors, including religious beliefs, and mentalities also influence the perception of contraceptives. An important obstacle in the promotion of contraceptives is the subordination of women in sexual matters. When asked why they do not use contraceptives, Mexican women often answer that their male partner does not want to use any; he finds it unpleasant or unnecessary. Another argument regularly brought up by men is that using contraceptives would allow their woman to be unfaithful without them noticing it. In this matter, women are submissive, and follow their partner's wishes. Thus, in fact, men control women's bodies. Yet with their submission, women are putting their own health seriously at risk. Empowering women, but also raising awareness of Mexican men, should thus receive special attention.

But most important in this matter is to improve sexual education and prevention, both for women and men. There is a clear lack of knowledge and awareness regarding reproductive health, and especially regarding related health risks. This lack of knowledge is largely due to deficient sexual education and insufficient prevention. During the last decade, Mexico has started to commit to improve sexual education. In 2008, in the context of the XVII International AIDS Conference, the Mexican government signed the Ministerial Declaration "*Preventing through Education*" (UNAIDS, 2008). The commitment of the Mexican government in this matter is essential. Not only does the government decide on the national education policy and the educational curriculum to be followed, the Secretaría de Educación Púbilca (SEP) is also responsible for the publication of the official primary education text books that are to be used as basic learning material in all Mexican primary schools[56]. The SEP distributes these books to both public and private, urban and rural schools. Students get the books at no cost. In theory this implies that all primary school pupils in Mexico, irrespective of social class or financial means, have access to the same basic learning material. Sexual education has gradually been included in the curriculum. The SEP natural science text books of the 4th, 5th, and 6th grade of primary school, now include chapters on sexual education, personal hygiene, and

[56] Schools are obliged to use the SEP text books, but they can add complementary material of their choice.

sexuality[57]. However, this is a recent trend, and unfortunately the presence of sexual education in the text books does not guarantee adequate sexual education in all Mexican classrooms.

In the Mexican context, sexual education and adequate prevention is crucial to address health problems that especially affect women. It is very important to continuously educate adults and young people on the dangers of having unprotected sexual relations, on how to prevent unwanted pregnancies or diseases, and on the existing possibilities for family planning. This sexual education should be repeated regularly at school and it should also be adapted to the specific cultural context of indigenous peoples (e.g. given in their own language). Sexual education and prevention campaigns should result in well-informed and conscious citizens. As family planning empowers people, it will not only be beneficial in a health context, it will also have a positive impact on the socio-economic development of entire communities.

C. Maternal Health: Illustrating the Need for an Intercultural Approach to Health Care in Mexico

In addition to reproductive health risks, Mexican women also have to deal with risks related to maternal health. In the case of indigenous women the persisting problems illustrate the precarious health situation they are still facing.

1. Maternal Mortality in Indigenous Regions: Indicator of a Larger Problem

Pregnancy and delivery are natural processes that, in most cases, do not lead to any complications for mother nor child. However, in Mexico maternal mortality is still an important health problem. In 2007, an average of 57.6 women for every 100,000 live births, did not survive child bearing. Every day, three women died due to complications during or after pregnancy or delivery. Maternal mortality is a problem closely linked to situations of poverty, and lack of medical care. In Mexico, the highest maternal mortality rates can indeed be found in the poorest states, Chiapas and Guerrero (INEGI, 2009c: 70). In 2007, these two states had a maternal mortality rate of respectively 100.6 and 99.2 out of 100.000 live births. In comparison, in the rich northern state of Nuevo León, the maternal mortality rate in 2007 was 23.4 out of 100,000 live births (INEGI, 2009c: 70). In 2012, the numbers had slightly improved, with a national average of 42.3 maternal deaths for every 100,000 live births. Guerrero became the state with the highest maternal mortality, with 75.9 mothers dying for every

[57] For example: SEP (2011), *Ciencias naturales. Cuarto grado*, Mexico: SEP, p. 11-15; SEP (2011), *Ciencias naturales. Quinto grado*, Mexico: SEP, p. 35-43; SEP (2011), *Ciencias naturales. Sexto grado*, Mexico: SEP, p. 35-43.

100,000 live births. In 2012, the prosperous state of Queretaro recorded the lowest mortality rate of 19.8 (INEGI, 2012d).

It must be stressed that existing statistical data on maternal mortality in Mexico are merely estimates. Exact data are unavailable as there is no systematic record of maternal mortality. For example, the research of Graciela Freyermuth (CIESAS-Sureste) in the municipality of San Pedro Chenalhó in the Central Highlands of Chiapas, shows that in this community 90% of the deceased has no death certificate, and no doctor comes by to determine the cause of death. Moreover, women, who according to their family died in child birth, are often given another cause of death (González Montes, 2003: 9). This example illustrates that maternal mortality is still an invisible problem in Mexico. And unfortunately, addressing this issue seems not to be a priority for the authorities. Furthermore, the relatively high numbers of maternal mortality are an indicator of a larger problem related to maternal health: the need for more adequate medical support, education, and prevention.

Major maternal health problems occur in rural areas, where pregnant women do not receive sufficient medical attention. Not all women give birth in the presence of a doctor. This is more often the case in states with low socio-economic levels and high rates of indigenous population. In 2006, the national health and nutrition survey indicated that in Guerrero, Oaxaca, Chiapas, and Quintana Roo between 13% and 38% of women had not been attended by a doctor when delivering their child (INSP, 2006: 59). But, the latest national health and nutrition survey seems to indicate important improvements as it reports 99.6% of Mexican women giving birth between 2007 and 2012 were assisted by medical staff (INSP, 2012: 97). In fifteen states (Aguascalientes, Baja California, Baja California Sur, Coahuila, Mexico, Michoacán, Nuevo León, Quintana Roo, Sinaloa, Sonora, Tabasco, Tamaulipas, Veracruz, Zacatecas, and the Federal District) 100% of the deliveries would have been assisted by medical staff. Yucatán has the lowest scores, but still in 98.2% of the deliveries medical staff would have been present (INSP, 2012: 97-98). The improvements could partly be explained by a more detailed questioning. The survey of 2006 only counted the women attended by official doctors and nurses. It did not include women attended by a traditional midwife or *partera*. Since 2009, the official statistics of the INEGI include data on the presence of a *partera* during the delivery. For 2013, it can be observed that for example in Chiapas, only 44% of women were attended by a doctor or a nurse, but a *partera* assisted in another 40.7% of the deliveries, nearly doubling the number of attended deliveries in that state (INEGI, 2013d). This puts the improvements made into a different perspective. The inclusion of more extensive information gives a new and more complete image of the situation. It also shows the importance of the traditional *partera*. Her role will be discussed further on.

2. Health in an Intercultural Context

Health care for indigenous peoples has two components: access to health care services, and the respect for their traditional medicine and medical practices. Improving the number and the quality of medical resources in rural areas is certainly necessary. However, providing more health centers and medical staff will not resolve all problems. In addition to access to medical resources, cultural factors also play a key role in improving the health care for indigenous patients.

Graciela Freyermuth comments how in the Central Highlands of Chiapas women who have complications during pregnancy or delivery do not consider going to the existing health center as an option, often resulting in the death of the mother (González Montes, 2003: 9). Why not go to a doctor when one is available? Indigenous women can feel uncomfortable visiting a 'Western' allopath doctor. There are several factors that can generate this aversion towards these 'modern' doctors. First, indigenous women not only enter the unfamiliar environment of the health center, they often cannot directly communicate with the doctor and the nurses as they do not always speak Spanish, the language of the medical staff. The doctor is most often not from the same region as his patients, he is not indigenous, he is not familiar with the local culture, and cannot speak the local indigenous language. Furthermore, even if the patients speak Spanish, the medical vocabulary of the doctor will scare people with a limited level of education. In addition, due to years of discrimination and oppression, many indigenous persons feel inferior to the mestizo doctor, afraid to ask anything, and feeling they have to accept everything the doctor says. The doctor may reinforce this feeling by treating his indigenous patients as ignorant and dumb, a behavior that is not uncommon in Mexico.

Given the inequality in the relation and communication, and the experience of arrogant, condescending, or offensive attitudes, not in accordance with cultural traditional values, another important issue for indigenous women is chastity – interpreted by the dominant party as shame. Women can in the first place feel too uncomfortable to ask the strange doctor – who is an outsider, coming from a hostile dominant group – a question about intimate issues (Cosminsky, 2006: 27), let alone allowing him to have any physical contact. Particularly gynecological examinations are a difficult matter as the women have to undress, and be examined in their most intimate parts. The feeling of being uncomfortable, not being understood, and even being exposed to offensive behavior will only be reinforced if the doctor is a man. Having to undress and being placed in a very intimate position with a strange man, who cannot communicate with them and whom they might not understand, is not conducive to a relationship of trust that should exist between patient and doctor. Moreover, a husband can also object to his wife going to a male doctor. As Freyermuth testifies, depending on the sex of the doctor, pregnant women might decide to seek or not to seek medical attention (González Montes, 2003: 10). Flor Julián confirms this information. As a doctor, she

experienced how women in certain communities in the Highlands of Chiapas could only be examined in the presence of their husband. Furthermore, some of them refused to undress, even for a female doctor, thus Julián had the almost impossible task of examining these women fully dressed (Julián, personal communication, 2012). Cultural factors play thus an important role, as they can have an influence on the medical care for the pregnant woman, her health, and wellbeing.

For Araceli Gil, another problem is what she calls the 'psychosis' within the medical staff to be the first providers of medical care to pregnant indigenous women. Gil feels there is a certain reluctance to attend indigenous women because there are many eyes, both at a national and international level, looking at the matter of maternal health. As the aim is to attain the millennium goals, a maternal death has a very high public cost. As a result, the responsibility is passed on, and women with basic complaints are immediately referred to a higher level of specialized medical attention, causing a bottleneck in services intended for special cases. These services are usually not located in their own area and travelling implies a very high cost for these women. According to Gil, in these cases the medical staff is not reluctant because of potential communication problems. They are not afraid, because there is a hierarchy in which they have the power to decide. Gil says: "If only they were scared of culture…"; it would mean they understood the importance of the cultural context for their work. Unfortunately, at this moment, this is the last of their concerns. Communication is not conducted from a cultural perspective, nor in a local language (Gil, personal communication, 2011).

Another issue is the relationship between allopath and traditional medicine. The patients in indigenous communities and the medical staff are part of different cultures; they have other beliefs, traditions, customs, values, and ethics, and often speak another language. The doctors and nurses are mostly Spanish speaking mestizos brought up in an occidental cultural context. In Mexico, traditional indigenous culture is being regarded as inferior. It is treated with little respect, and indigenous peoples are racially discriminated. This is also the case in health care. Traditional indigenous medicine is often identified with quackery. Mexican allopath doctors do not respect traditional medicine nor local beliefs; they consider them to be partly superstition and certainly without any scientific basis (Sandstrom, 2001: 309). However, research has shown that traditional medicine includes very valuable knowledge, especially about local plants and culturally specific symptoms (Campos, 2006: 9). The lack of respect and understanding on the side of the allopath doctors complicates the relation between doctor and patient.

People in indigenous communities do go to allopath doctors when they feel traditional medicine cannot help them. Some people prefer allopath medicine because they consider it to be 'modern' and therefore better. But, curanderos themselves can also recommend patients to consult allopath

doctors for certain diseases. Sandstrom for example, reports on curanderos that encourage people to vaccinate their children in medical centers. Indigenous peoples do not necessarily see a contradiction between traditional and allopath medicine (Sandstrom, 2001: 309). However, the traditional medical practitioner is often the only available source of health care. Furthermore, negative experiences with allopath doctors discourage people to visit them, taking thus serious health risks.

Mexican government has made efforts to improve the access to health centers, but many regions still lack the necessary services. Western health centers cannot always offer the help indigenous peoples require, in particular for illnesses and diseases that are cultural in nature. In indigenous Mexican communities, for example, *mal de ojo*, *mal aire*, and *susto* or *espanto* are common. Physical discomfort or pain is in these cases believed to be caused by negative influences of envy, sorcery, bad vibes, or other perturbations of the natural and social order. For example, in the case of *susto* an individual is believed to have lost his soul after a frightening or traumatizing experience. To be cured, the general equilibrium has to be restored. This can be achieved by performing the proper ritual, for example a ritual cleansing of the patient, known as *limpia* (passing an egg and/or herbs over the body of the patient), and by offering goods such as food, mezcal, or other specific products, to the gods or saints. The patient may also receive a treatment with medicinal herbs[58]. Western doctors consider these illnesses to be folk superstition. Further research by medical specialists would be needed, but there are definitely similarities between these illnesses and certain psychological disorders known in Western psychology, such as post-traumatic stress disorder. In general, traditional medicine gives much more attention to the patients' psychological wellbeing than Western medicine, which is more focused on biological processes (Campos, 2006: 9-10, 14).

[58] On Mesoamerican concepts of illness and disease, see among many others: C. BELL (1992), "The Ritual Body", in: BELL, C., *Ritual Theory. Ritual Practice*, New York: Oxford University Press, p. 94-117; L. CRANDON (1983), "Why Susto?", in: *Ethnology*, 22:2, p. 152-167; B. R. HUBER and A. R. SANDSTROM (eds.) (2001), *Mesoamerican Healers*, Austin: University of Texas Press, p. 95-116; F. J. LIPP, (1988), "The Study of Disease in Relation to Culture: The Susto Complexe Among the Mixe of Oaxaca (Mexico)", in: *Dialectical Anthropology*, 12, p. 435-442.

An Intercultural Approach to Health Care

To improve the medical attention given to indigenous peoples, Dr. Roberto Campos Navarro[59], among others, advocates for an intercultural approach to health care in Mexico. Campos defines this intercultural health care as a relational exchange process between two or more cultures in a society that is otherwise economically, socially, and politically heterogeneous, such as is the case in Mexico (Campos, 2006: 6). Intercultural medicine is thus seen as "the practice and relational process established between health personnel and patients, where both belong to different cultures, and that requires a mutual understanding so that the results of the contact (consultation, intervention, counseling) are satisfactory for both parties (Duarte et al., 2004: 389)."

The state of Oaxaca, for example, has eighteen main indigenous peoples. Many of the communities live in a situation of marginalization. According to Dr. Campos, during the last years hundreds of rural hospitals and medical centers have been built on Oaxaca's territory. However, this does not mean that everybody goes to these centers. For Dr. Campos, the reason is lack of an intercultural approach to health (Campos, 2006:6).

Living in a multiethnic and multicultural society, Dr. Campos believes that it is essential for Mexican medical staff to receive intercultural training. Yet medicine students currently receive no such training, nor workshops in medical anthropology. Illness is seen as something purely biological, and the management of a health center is a financial and administrative affair; culture is not considered part of it (Campos, 2006: 6; Julián, personal communication, 2012).

Adopting an intercultural approach is not only an obligation for the medical institutions, but should be viewed as essential by all individuals working in the medical sector, as an obligation to offer the best possible service to the patients. The medical practitioner does not have to share the same beliefs or practices as the culture of his patient, but he has to know and respect them. Campos advocates that medical staff should, both at an individual, collective, as well as institutional level, learn as much as possible about the community they are going to work in (Campos, 2006: 8-9, 14).

For Campos, an intercultural approach to health care must not only include the relationship between patient and doctor, it is a process that must include everybody involved in health care, be it the ambulance driver, nurse, health care policy adviser, or even architect of the hospital. Presently, the local communities, for example, are not consulted when a new medical center is built.

[59] Dr. Campos Navarro is a medical doctor with a PhD in social anthropology. He is currently professor and research coordinator in the Department of History and Philosophy of Medicine in the Faculty of Medicine of the UNAM, Mexico City.

An intercultural approach to health should be introduced in all hospitals and health centers, both in the public and private sector, and especially in vulnerable areas. Specific adaptations can improve the medical care and make it able to reach more people. Campos gives some examples of such adaptations: providing sleeping accommodation for the family members who travelled along with the patient, instead of letting them sleep on the floor; providing local food for patients; using the *temazcal* or steam bath in post-partum treatments; offering hammocks in regions where these are more commonly used than beds; adapting the consultation hours to the rhythm of rural farm life (Campos, 2006: 15). Another concrete example mentioned by Campos is that of a doctor who worked in a Maya community of Campeche. He allowed women to deliver in a hammock, as they have always been accustomed to, and thus gained the respect and trust of the community (Campos, 2006: 5).

Certain indigenous peoples divide their surrounding world in classifications of 'hot' and 'cold' elements. As the natural equilibrium has to be preserved, too much exposure to 'hot' or 'cold' substances can trigger disease[60]. Pregnant women are considered to be in a very 'hot' state. Eating or drinking aliments considered to be too 'cold' can harm the mother or the unborn child. After delivery, women become very 'cold'. They have to drink and eat food, such as chicken broth, grilled meat, and vegetables that are considered to be 'hot', stimulating blood flow and ensuring good lactation. Cold food, such as sour fruit (lemons, oranges), avocado, 'cold' vegetables, or pork is prohibited (Cosminsky, 2006: 27-28; Katz, 1993: 100-103). More research is needed to understand which of these aspects of a culturally defined diet are useful. The hospital diet could be adapted to local customs. If the medical staff is aware of this custom, problems can be avoided and a relationship of trust can be built. A doctor who is aware that he is asking a mother to accept 'cold' food after delivery, can, for example, offer to combine it with a 'hot' item instead of firmly opposing the patients' request. The women will be much more willing to follow his advice if the equilibrium is maintained (Cosminsky, 2006: 28-29). Dr. Roberto Campos Navarro describes the experience of a nutritionist, who reprimanded Maya women who had just given birth and refused to drink the watermelon juice she gave them. The reason for this refusal was that Maya women consider this drink to be too 'cold'. Drinking it can make the still 'hot' uterus 'cold', and cause infertility (Campos, 2006: 5).

In indigenous communities the use of steam baths is considered to be good for personal hygiene, but also as a ritual cleansing. The ritual is psychologically and culturally important for the mother. Western doctors discourage the use of steam baths because it would weaken the mother and could

[60] The categories of 'hot' and 'cold' do not refer to Western ideas of temperature.

cause hemorrhages. However, little research has been done on the real effects (Cosminsky, 2006: 24). The same is true regarding the use of traditional medicinal herbs. Western doctors dismiss their use. However, some plants are known to be effective. Furthermore, patented medicines may be too expensive or inaccessible for people living in rural communities. Yet some of Western chemical medicines could be replaced by local medicinal herbs. The use of local medicinal plants in cases where this practice is a good alternative, would not only be less expensive for the patients, but would also bring patient and doctor closer together as the doctor would show interest and respect for the local traditions and life style. More research is needed to better understand the medicinal qualities of these herbs, and to determine which ones can be useful, do not harm patients, are suitable for rituals, or should be altogether avoided.

Campos also recommends to rely on traditional medicine practitioners when needed. Certain traditional practitioners could, for example, be given a place within institutionalized health centers. The main practitioners in indigenous medicine are the *curanderos* and *curanderas* or healers, and the *parteras*[61]. Currently, the value of these practitioners is not recognized outside their community, let alone by professional medicine. Working together with the traditional *parteras* could, for example, be an interesting cooperation.

3. A Role for Traditional Medicine: The '*Parteras*' and the Humanization of Delivery

The use of traditional medicine and health practices should not be romanticized. When confronted with serious health problems, it is important that the patient is attended by trained medical staff with the necessary medical infrastructure. There are however roles to play for traditional medicine One such example is traditional midwifery. The midwife or *partera* is a woman of the community who supports women during pregnancy, delivery, and in post-partum. She can also give massages, herbal treatments, and advice, and she performs the necessary rituals. Her presence and support can help relief the anxiety of the young mother-to-be. The rituals that accompany childbirth are part of the rites of passage within indigenous communities. For the mother, the delivery and postpartum are considered to be life crisis moments. The treatment for new mothers has physical as well as psychological, symbolical, and ritual dimensions. They help her to make the transition from pre-motherhood to motherhood, and to restore her position within the social structure of society.

The *partera* is usually trained by an older *partera* in her community, and knows all local customs and traditions. In many cases she has had a vision or dream in which she was called to become a *partera*. Although they are not trained doctors, experience allows *parteras* to develop a level of medical

[61] For more information on Mexican traditional practitioners of indigenous medicine see for example: B. R. HUBER and A. R. SANDSTROM (eds.) (2001), op. cit.. The introduction to this work includes an extensive bibliographic overview of the research on Mesoamerican healers.

knowledge – similar to that of professionally trained midwives – which qualifies them to accompany a mother during a standard delivery (Cosminsky, 2006: 22).

Like all traditional medicine, midwifery has suffered historic discrimination. Discrimination of *parteras*, however, is based on four elements. First, midwives suffer discrimination because they are indigenous, secondly because they are women. Midwives often live in poverty, and thus they have been discriminated because of their low economic status. Finally, in medical hierarchy, midwives are located in the lowest echelons, leading to discrimination by all other medical practitioners (Gil, personal communication, 2011).

In indigenous communities many changes are occurring and people also turn their back on certain traditions. Not all indigenous persons necessarily prefer traditional medicine. Some consider modern clinics and private doctors to be better than traditional healers. If affordable, people may prefer to go to the health center. When asked whether in the future she would consider going to a traditional *partera* or to an allopath doctor to give birth, a teenage Triqui girl answered:

> "The girls that do not study go to the *partera*. I already know better, I would go to the doctor. My sister had a problem while she was pregnant, and both she and her child could die. They went to the doctor and he could save both (Lucía, personal communication, 2012)."

Fernando, a Triqui university student, on the other hand says:

> "The doctors do not respect our knowledge. The wife of my cousin was pregnant, but the child was not correctly positioned. Our ladies have knowledge to turn the child. They touch it, I don't know how they do it, but they touch it and the child gets in the right position, and they do not need to cut the woman. Because that is what doctors do; they say there is no solution, and they cut the mother.
>
> Our ladies have knowledge, and they do not need to hurt the mothers. My cousin went with his wife to see a doctor and he said he would have to cut, and they told him that the Triqui have this knowledge to turn the child. He told them this was impossible. And they said: "You will see, doctor, we will bring him to you well positioned." And that is what happened, and there this doctor understood our traditions, and he was astonished. And now, when he has a doubt, he asks us. And we trust him more because he respects our knowledge (Fernando, personal communication, 2012)."

Fernando indicates he prefers traditional medicine. Yet, his testimony also shows how allopath doctors can gain the trust of the community by showing respect for traditional knowledge.

For Alejandra, another Triqui girl, the *partera* can be consulted for a normal pregnancy, but if there are any complications, one should go to the doctor (Alejandra, personal communication, 2012). Thus, these three testimonials show that the preferred type of health care often depends on personal experiences and points of view.

National aid programs, such as the *Oportunidades* program, encourage their beneficiaries to go to official doctors and recognized health centers in order to improve the health care of people living in rural communities. As a result, pregnant women in these programs will not have the opportunity to choose a traditional *partera* to support them (Gil, personal communication, 2011). The discrimination and the encouragement to go to allopath doctors makes indigenous women turn away from the *parteras*. Yet the *parteras* might have an important role in the humanization of the delivery process.

Lately, Western treatment of pregnancy and delivery has been increasingly criticized because of its impersonal and purely biological approach. Due to a growing demand for the humanization of child birth, some have turned to the more intimate practices used by traditional midwives.

In traditional midwifery the mother is the protagonist of the delivery. The midwife works in a specific cultural context, with certain beliefs and values. She works in an intimate setting, where delivery is seen as a sacred, special event. The experience of a 'Western' delivery in Mexico is very different. In Western medicine, maternity is treated as a pathology, and attention is given in the context of this pathology. Women have no say in the way they are treated. Decisions are made by the doctor, based on scientific eminence (Gil, personal communication, 2011). This is a generalized approach for indigenous and non-indigenous patients alike, be it in rural or urban areas, in private or public health care centers.

In 1985, the WHO formulated general recommendations on the humanization of delivery (WHO, 1985). The main focus of the delivery should be the physical and emotional well-being of the mother. According to Araceli Gil, these recommendations are not being followed in Mexico. For example, women often have no freedom of movement; they cannot choose the position of delivery nor who accompanies them. The supine position generally used in Western deliveries (lying on the back), is not optimal for child birth. The squatting position, used in traditional medicine seems to be much more effective as gravity helps the child descend with less effort from the mother. Already in the 1970s, the Uruguayan doctor Roberto Caldeyro-Barcia, then director of the Latin-American Center of

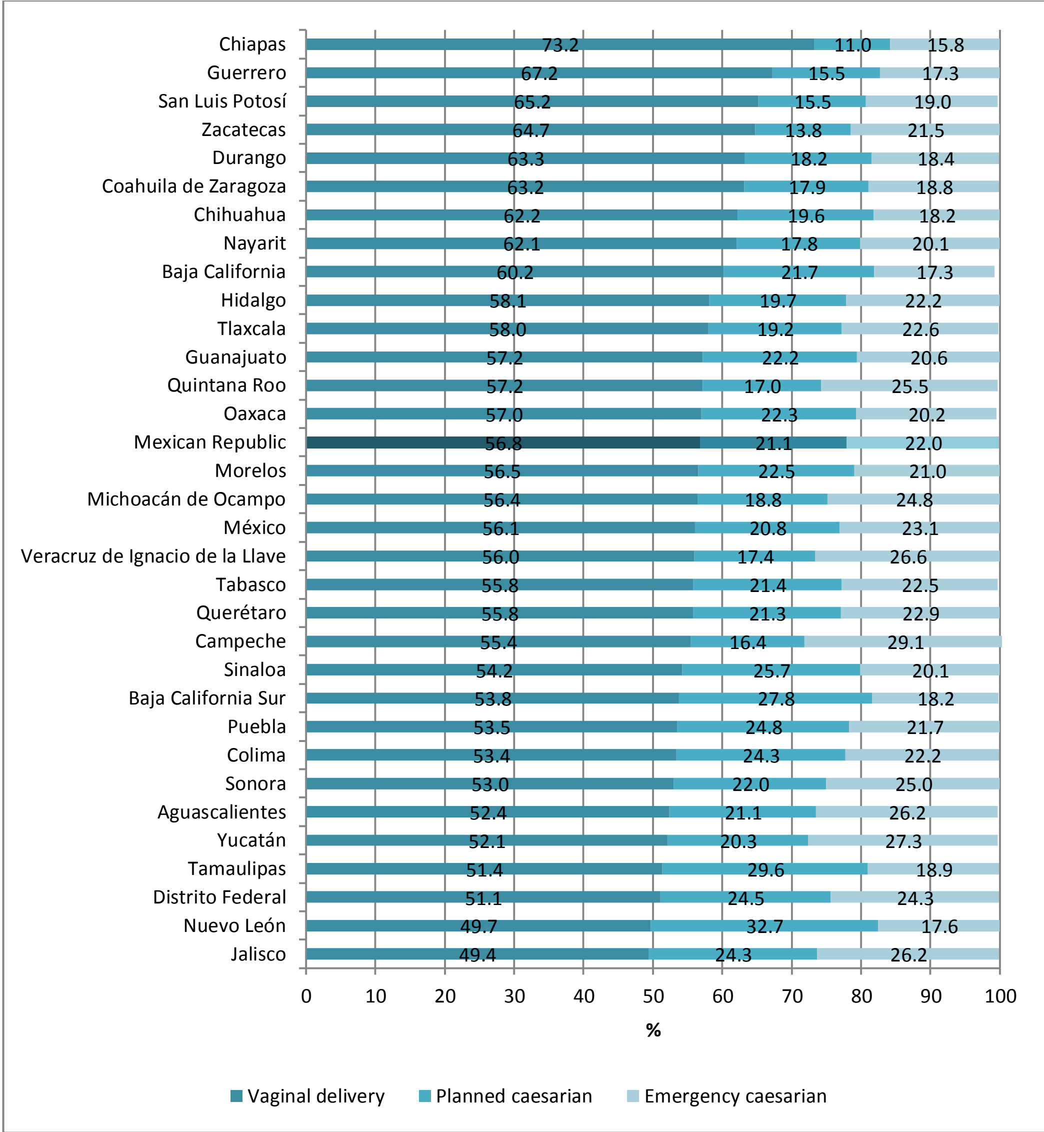
Perinatology and Human Development of the Pan American Health Organization, and president of the International Federation of Gynecologists and Obstetricians, declared: "Except for hanging by the feet, the supine position is the worst position for women during delivery (Caldeyro-Barcia in Cosminsky, 2006: 22)". In traditional medicine, women are attended depending on their necessities; in Western medicine women seem to be attended depending on the necessities of the doctor (Gil, personal communication, 2011).

Furthermore, women are not informed about important procedures, such as episiotomies[62] or caesarians. The percentage of caesarian sections in Mexico is extremely high. On a national level, 43% of all deliveries between 2004 and 2009 were caesarians. The states with the lowest percentages of caesarians were Chiapas and Guerrero, with respectively 26.8% and 32.8% of caesarian sections. This can be explained by the fact that women in these more marginalized regions have less access to institutionalized medical care. The states with the highest percentages of caesarians are the more prosperous states of Jalisco, Nuevo León, and the Federal District, respectively with 50.5%, 50.3%, and 48.8% of caesarian births (INEGI, 2009b: 43). These numbers are exceptionally high. Already in 1995, the Secretaría de Salud recommended a national standard of 15% to 20% caesarian births, but this norm has not been observed[63] (Secretaría de Salud, 1995). Furthermore, in Nuevo León a striking 32.7% of all deliveries between 2004 and 2009 were performed by a planned caesarian section (see figure 5) (INEGI, 2009b: 43). Planning a caesarian is in some cases necessary for medical reasons. But, planning a caesarian also gives the obstetrician the possibility to perfectly schedule all his or her deliveries, as he or she can define the exact hour and date of the procedure. In Mexico, doctors in private clinics in particular are tempted by this practice. In 2012, as many as 42.3% of all deliveries in Mexican private clinics were planned caesarians (INSP, 2012: 100). The World Health Organization has been pointing out the increased health risks related to unnecessary caesarian sections and labor inductions (Souza, 2010). Furthermore, if there are no actual medical reasons, it denies women the right to listen to the necessities and the rhythm of their own body. Their right to take decisions on how to give birth and how to experience this moment is negated to better suit the doctor. Thus, the humanization of the delivery process would not only be beneficial for indigenous women, but for all women giving birth in Mexico.

[62] A surgical incision made on the perineum and the posterior vaginal wall during labor, to facilitate the baby's birth. In Europe and the United States the use of this technique is debated.

[63] The number of caesarians around the globe differs from country to country. According to the WHO, an estimated 25% of all deliveries worldwide are done by caesarian sections (WHO, 2010). By comparison: in 2004, Belgium recorded, just over 18% caesarian births (Intermutualistisch Agentschap, 2006: 10), whereas the Netherlands reported 15% caesarian births that same year (Stichting Perinatale Registratie Nederland, 2007).

Figure 5: Percentage of pregnancies according to the type of delivery for each federative entity, Mexico (Last pregnancy occurred between 2004 and 2009) (INEGI, 2009b: 43).



Some government initiatives include traditional medicine in professional health care. For example, official training courses for traditional midwives have been organized in the past. However, these courses have mainly focused on hygiene, and on recognizing when to send future mothers to the doctor. While these subjects are important, there has been little attention for the traditional knowledge of the *parteras*. Traditional practices are criticized, and *parteras* are forced to accept Western ones, such as the supine position and the use of patented medicine. Furthermore, as Araceli Gil also testified, the medical staff does not respect nor trust the *parteras* and considers them to belong to the lowest category of medical staff (Cosminsky, 2006: 29-33; Gil, personal communication, 2011).

Other actions are taken to include traditional medicine in official Mexican health care, for example, the translation of prevention leaflets in several indigenous languages, the presence of interpreters in certain hospitals[64], workshops on health care for traditional practitioners, etcetera. However, these are mostly local and ad hoc initiatives. While such initiatives are definitely important, more structural actions are needed, valuing and respecting traditional medicine, addressing the mentality of medical practitioners, and leading to a real exchange of medical practices between allopath and traditional medicine.

Due to a limited amount of staff and medical centers, there is a lack of medical attention in rural areas. Traditional practitioners could play a role in the follow-up of pregnant women. It is important to give them some basic training, but including respect for traditional elements considered positive, such as eating chicken broth, giving massages, accepting the squatting position, etcetera. Neutral elements, such as prayers, should be accepted as they may have a positive psychological effect, facilitating the delivery. Negative practices, such as bad hygienic conditions, or the use of dirty rags, should be corrected through education and training, showing there are alternative and safer techniques for the patient. More research is needed on the use of medicinal plants and the exact effects traditional medicine has on patients (Cosminsky, 2006: 34).

The most important step when developing adequate health care for indigenous peoples is to communicate with the local communities. Their specific needs and demands have to be taken into consideration for initiatives to be effective. A recent study of Tucker et al. (2013) on the establishment of an intercultural birth house in the highlands of Chiapas illustrates the importance of communicating with the local community. To address the high maternal mortality rates in the state, the Secretary of Health of the State of Chiapas built an intercultural birth house next to the hospital in the indigenous community of San Andrés Larraínzar. To make women more at ease, the birth house looked more like an indigenous house than a hospital, and women could give birth with their own *partera*. If needed the medical staff of the hospital was next-door. However, after three months, not a single woman had given birth in the birth house. Research revealed that the birth house was no success because women had a preference for home births, and that the transport costs to get to the birth house were too high for many of them. This research shows the importance of participation of the community and of the *parteras* in planning and implementing these kinds of services. Such communication will not only make it possible to develop effective projects, it will also improve the

[64] This is for example the case in the state of Querétaro, where a law was voted in 2014 providing Otomí interpreters in health centers of the Secretaría de Salud located in regions of this state with large numbers of indigenous population (AM Querétaro, 2014).

mutual respect and understanding between authorities, medical staff, and the community (Tucker et al., 2013).

Flor Julián also emphasizes the need to include communities in the planning of health care centers. She recalls the construction of a new health care facility, specifically meant for traditional medicine. It was a nice and clean space, with spotless white walls. However, indigenous women did not like giving birth in these white rooms, because they were considered too 'cold', and thus not good for birth giving. For Julián, these kind of problems stem from the fact that health care programs are designed behind a desk, by a person who has never been to the concerned communities. Furthermore, programs cannot simply be translated from one community to another. The state of Oaxaca for example, has many different indigenous peoples, with different characteristics and needs. Specific analysis are necessary to define which programs would be most effective and beneficial for the communities (Julián, personal communication, 2012).

D. Conclusion

The rights of indigenous peoples regarding health care are twofold. On the one hand, indigenous peoples should have equal access to qualitative institutional health care services without being the subject of discrimination. On the other hand, there should be respect for their traditional medicine and healing practices. In Mexico, neither of these rights is yet guaranteed.

The general health care situation in Mexico has improved during the last decades. But certain important issues remain. Both the quality and quantity of medical services differs widely. People living in rural and marginalized regions have most difficulties, both physically and financially, to access health care. This is especially the case for indigenous peoples. Furthermore, women and children are the most vulnerable.

Women are still facing basic health risks, especially regarding reproductive and maternal health. During the last decade, family planning campaigns resulted in a decrease of fecundity rates in Mexico. But, these campaigns have had their limitations. The use of contraceptives has been promoted by state campaigns, and a majority of people has a certain knowledge of contraceptive methods. However, the use of these methods does not seem to be evident for everybody. Especially in regions with a low socio-economic profile, people use less contraceptives, yet these are the regions potentially benefitting most from family planning.

Consequently, teenage pregnancy rates across the country, and particularly in more marginalized regions, including indigenous communities, are persistently high. Teenage pregnancies are hazardous as they entail important health risks both for the young mother and the baby. As Mexico has very high rates of teenage girls getting married, part of these teenage pregnancies occur within marriage. Most of these early marriages also take place in indigenous communities. In addition to the health risks, early marriage and teenage pregnancies limit the emancipation of women, because girls quit secondary school upon marriage or pregnancy, and do not pursue further education. This limits their opportunities for the future and their possibilities to become economically independent. In certain cases girls are forced into marriage and are even sold to their husband. According to existing reports, most of these cases happen in indigenous communities. This topic is relatively frequently commented upon in press and social interaction, but precise and in-depth studies have not been published. The Mexican government has not taken action to stop these practices of women and child trafficking, and tends to hide behind the argument that it is part of the '*usos y costumbres*', even though indigenous women's organizations have condemned these practices. In general, and as part of a general focus on gender in policy making, the government should take action to limit the number of teenage marriages and teenage pregnancies. However, with the exception of a few local initiatives, currently little attention is given to the subject, and the Civil Code legally accepts early marriages. By raising the minimum legal marriage age in the Civil Code, the government would signal commitment to protect the health of women, and support their general emancipation. But, as the church wedding is more important in Mexico than civil marriage, amending the legal framework would only have limited results. The Church too should play a role in this matter and encourage girls to finish high school before getting married.

Undesired pregnancies could be terminated by aborting, but abortion remains a taboo topic in Mexico. Although progress had been made, there has been a retrogression in Mexican abortion laws. In 2014, abortion was penalized in 17 out of 32 states, making it legally impossible to get an abortion by a certified medical practitioner. As a result, unsafe abortions, entailing important health risks for the mother, increase. Women in marginalized situations are again most vulnerable. In Mexico, the Church is the fiercest opponent of abortion. This institution has managed to influence politics and Mexican society in general, resulting in a very strong anti-abortion movement. The anti-abortion policies are implemented without offering alternative actions, such as better sexual education and awareness campaigns to prevent abortions, or the creation of social security systems supporting teenage mothers. Thus, the state gains control over women's bodies – depriving them of the right to decide over their own bodies –, but without offering other realistic options to prevent or address unwanted pregnancies.

Family planning campaigns in Mexico have also been misused. In the past, there have been reports of forced sterilization of indigenous women and men. This is a severe violation of human rights and of the Mexican Constitution, as it denies people the right to decide on their own family planning. At international level, forced sterilization is considered to be genocide. More research is needed to know if the reproductive rights of indigenous women are respected in Mexico. The government needs to address this issue instead of hiding behind the '*usos y costumbres*' system as it currently does.

These different situations related to reproductive health show that women in regions with a low socio-economic profile, and especially indigenous women, are most vulnerable for health risks. Moreover, there is an urgent need for more sexual education and prevention. This would in the first place reduce health risks for women. Being well-informed and able to decide on their family planning also empowers people. The emancipation and empowerment of both women and men would have a positive impact on the socio-economic development of individuals as well as communities.

In addition to reproductive health risks, Mexican women also face risks related to maternal health. The persisting problems illustrate the precarious health situation which especially indigenous women still encounter.

Mexico still has high levels of maternal deaths, particularly in the poorest states with the highest numbers of rural and indigenous communities. Pregnant women in these regions do not get sufficient medical attention. Although there have been improvements, there are still women giving birth without the assistance of medical staff, which entails serious health risks. This situation is an indicator of a larger problem in Mexican health care: the lack of adapted health care for indigenous peoples. In the first place, it would be important to increase the number and the quality of health care centers and medical staff. But, when working with indigenous patients, another issue often forgotten in Mexican medicine becomes apparent: the cultural context. Culture can have an important impact on the experience of illness and health care. As the medical staff and the indigenous patients have a different cultural background, difficulties arise in their contacts, especially because allopath medical practitioners have no knowledge of and no respect for traditional medicine. As a result, some indigenous persons avoid going to the health center, taking important health risks.

Therefore, there is a need for an intercultural approach to health care in Mexico. This approach implies respect for traditions within the institutionalized health care, but also cooperation with traditional practitioners. A systematic cooperation with the traditional *parteras* would be valuable when following-up pregnant women and assisting during standard deliveries. This cooperation would

make it possible to reach more women. Furthermore, the approach of the *partera* could be adopted in the process of the humanization of delivery. Introducing certain elements of traditional midwifery would be beneficial not only for indigenous women, but for all Mexican women. There is a need for training of the *parteras*, but this should be a training that respects traditional medicine and adopts best practices from both worlds. More research is necessary to better understand all elements of traditional medicine in general. It is important not to romanticize indigenous medicine, but to recognize the elements that are valuable both for Western and traditional medicine.

An intercultural approach to health care would help reduce the health risks for indigenous peoples, and more particularly indigenous women. The health risks indigenous women are facing are very basic health issues. Addressing these issues should be a priority for the Mexican government, but this is not yet the case. Ad hoc initiatives and local actions take place, but there does not appear to be a consistent policy to resolve these basic health issues. The situation in indigenous communities is most often ignored.

An important problem in this regard is the lack of statistical data and correct information on the health situation in indigenous communities. It is important to be able to estimate the extent of the problem in order to take the necessary measures, yet complete statistics are unavailable for several key topics, such as maternal mortality. Consequently, certain health issues of indigenous peoples are invisible. The lack of data shows a lack of commitment by the government. For such important topics, the government should make sure that the required data is collected, and a consistent policy in the interest of the people is developed.

Indigenous communities in Mexico are confronted with significant problems regarding health and health care, but these problems often remain invisible. Here anthropologists, advocates, and indigenous experts could play a role as they could help denounce this situation by emphasizing the reality of indigenous peoples' living conditions and the need to pay attention to the voices of the communities. Through their research, they can draw the attention to certain issues, such as inadequate health services, high levels of maternal mortality, cases of teenage marriages, forced sterilizations, etcetera. In addition, they could point at the difficulties indigenous peoples encounter when visiting allopath doctors. Finally, they could show the role traditional healers play in indigenous society, and the advantages of an exchange of best practices between traditional and allopath medicine.